DOH/BES/CHIP
Form 116M - 05/2005

Utah Department of Health

EMPLOYER INSURANCE INFORMATION

To be completed by the employer or Human Resource Department

Employed Person	**SSN**

1. Does your company offer any health insurance (regardless of whether the above employee has enrolled?) ☐ YES ☐ NO

2. Is the employee and/or family member's enrolled in any health insurance plan offered? ☐ YES ☐ NO
   If yes, list names of individuals enrolled.

   _____ _____
   _____ _____
   _____ _____

3. Is the employee eligible to enroll in any insurance plan offered? ☐ YES ☐ NO
   If no, please explain _____

Please complete the following questions. If more than one insurance plan is offered, please provide information on the *LEAST EXPENSIVE* plan.

Name of Insurance Company:_____
Does your company pay any portion of the insurance premium? ☐ YES ☐ NO
Do you require the employee to enroll in order to enroll their dependents? ☐ YES ☐ NO

Is there a waiting period before the employee can enroll? ☐ YES ☐ NO
If yes: How long is the waiting period:_____
Date the employee is eligible to enroll:_____
Date of next open enrollment (if applicable)_____

Have any individuals been dropped from the insurance in the last six months? ☐ YES ☐ NO
If yes: Name of individual(s) dropped: _____
Date coverage ended:_____

Insurance cost to employee: (circle one) Per check Per month
Do not include the cost of Dental, Vision, or other coverage, if separate.

Employee $_____ Family $_____
Employee + spouse $_____ Other $_____
Employee + dependent $_____
Yearly deductible (if applicable) $_____

Employer Information
Company Name:_____ Phone#_____
Company Address: _____
Insurance Contact Person:_____ Phone# _____

Employer Signature_____ Date_____
If you have questions, contact: _____

Mail completed form to:_____ or fax to: _____
_____
_____
_____